DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Centers for Medicare and Medicaid Services

Resource Summary

	Budget Authority (in Millions)		
	FY 2008 Estimate	FY 2009 Estimate	FY 2010 Estimate
Drug Resources by Function			
Treatment	170.000	220.000	240.000
Total Drug Resources by Function	**$170.000**	**$220.000**	**$240.000**
Drug Resources by Decision Unit			
Centers for Medicare and Medicaid Services	$170.000	$220.000	$240.000
Total Drug Resources by Decision Unit	**$170.000**	**$220.000**	**$240.000**

Drug Resources Personnel Summary			
Total FTEs (direct only)	0	0	0
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)	$619.0	$705.0	$763.0
Drug Resources Percentage	0.03%	0.03%	0.03%

Program Summary

Mission

The Centers for Medicare & Medicaid Services' (CMS) mission is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. Through its coverage of screening and brief intervention services for those at risk for substance abuse, the Medicare and Medicaid programs assist in achievement of the goals of the Administration.

Budget

CMS was designated as a National Drug Control Program Agency in 2007. CMS has established two Healthcare Common Procedure Coding System (HCPCS) codes for alcohol and drug screening and brief intervention (SBI).

Methodology

CMS actuaries provide estimates of the value of SBI services that might be identified if a certain number of states voluntarily elected to use the new codes. These estimates were intended to be illustrative of various levels of participation by the states. The HCPCS codes may be used to quantify the value of the services rendered, but only for those states electing to use them and not the national total. Furthermore, the Federal Government pays only a share of the Medicaid-covered services; the states also pay a share of the costs for SBI.

Healthcare Common Procedure Coding System (HCPCS) Codes

Total FY 2010 Estimate: $240.0 million
(Reflects $20.0 million increase from FY 2009)

CMS has provided states the ability to report on early intervention and treatment for substance abuse. On January 1, 2007, two new HCPCS codes were introduced to facilitate the reporting of Medicaid costs for alcohol and drug screening and brief intervention (SBI). These codes are available for health care providers and states to use, though there is no requirement to do so.

The first code, H0049, is for alcohol and/or drug screening. The cost for a screening is dependent on where and how it is carried out. The screening, a preventative service, is generally accomplished using a brief questionnaire concerning a patient's alcohol or drug use. It can be carried out in various settings, most likely a physician's office or a hospital emergency room. Based on data provided to CMS, the average cost of a screening a beneficiary is $21.00.

The second code, H0050, covers a brief intervention that generally occurs right after the screening. The brief intervention is a 15 to 30 minute brief counseling session with a health professional intended to help motivate the beneficiary to develop a plan to moderate their alcohol or drug use. The cost of the intervention depends on both the amount of time involved and the treatment. Based on data provided to CMS, the average cost of an intervention is $61.50.

These codes, when implemented by states, could improve the adoption of these services across patient status and diagnosis. It is intended that over time these approaches can be refined and improved to be more effective.

Some states began to implement the use of the new HCPCS codes during FY 2008. The amount of spending that would be captured by the use of these codes is dependent on the number and relative size of states which opt to use them. States implementing these SBI reporting codes are responsible for determining their own reimbursement cost schedule. These actuarial cost estimates assume:

- A 10 percent effective participation rate for FY 2008, FY 2009 and FY 2010;
- An average cost of $21.00 per each screening of a beneficiary;
- An average cost of $61.50 per each brief intervention; and
- A 15 percent probability that a given screening will lead to an intervention.

Based on these assumptions, the actuary has made estimates that are reflected in the table above.

Performance

The FY 2008 Performance Summary Report from CMS, in response to the ONDCP Accounting Circular, states that the agency is not planning on developing performance measures or targets. ONDCP will continue to work with CMS in developing metrics that represent their contributions.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Resource Summary

	Budget Authority (in Millions)		
	FY 2008 Final	FY 2009 Enacted	FY 2010 Request
Drug Resources by Function			
Prevention	564.492	576.747	574.367
Treatment	1,881.331	1,917.320	1,964.486
Total Drug Resources by Function	**$2,445.823**	**$2,494.067**	**$2,538.853**
Drug Resources by Decision Unit [1]			
PRNS Prevention	194.120	201.003	198.259
SPF-SIG (non-add)	*103.271*	*110.003*	*110.003*
PRNS Treatment	399.844	412.342	458.056
Access to Recovery (non-add) [2]	*96.777*	*98.954*	*98.954*
Screening and Intervention (SBIRT) (non-add)	*29.106*	*29.106*	*29.106*
Adult, Juvenile & Family Courts (non-add)	*10.132*	*23.882*	*58.882*
Offender Reentry	*8.200*	*8.200*	*23.200*
Prescription Drug Monitoring Program	0.000	2.000	2.000
Substance Abuse Prevention & Block Grant [3]	1,758.728	1,778.591	1,778.591
Program Management [4]	93.131	100.131	101.947
Total Drug Resources by Decision Unit	**$2,445.823**	**$2,494.067**	**$2,538.853**

Drug Resources Personnel Summary			
Total FTEs (direct only)	544	549	549
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)	$3.356	$3.467	$3.526
Drug Resources Percentage	72.9%	71.9%	72.0%

[1] Includes both Budget Authority and PHS Evaluation funds. PHS Evaluation Fund levels are as follows: $101.3 million in FY 2008, $110.5 million in FY 2009, and $110.5 million in FY 2010.

[2] Includes PHS evaluation funds for ATR in the amount of $1.4 million in FY 2009.

[3] Consistent with ONDCP guidance, the entire Substance Abuse Block Grant, including funds expended for activities related to alcohol is included in the Drug Budget. The Block Grant is distributed 20 percent to prevention and 80 percent to treatment.

[4] Consistent with ONDCP guidance, all SAMHSA Program Management funding is included. Program Management is distributed 20 percent to prevention and 80 percent to treatment.

Program Summary

Mission

The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to build resilience and facilitate recovery for people with, or at risk for, substance abuse and mental illness. SAMHSA supports the Administration's efforts through a broad range of programs focusing on prevention and treatment of drug use. Major programs include the Substance Abuse Prevention and Treatment (SAPT) Block Grant, competitive grant Programs of Regional and National Significance (PRNS), and a Prescription Drug Monitoring program, which was new in FY 2009. These programs are administered through SAMHSA's Center's for Substance Abuse Prevention (CSAP) and the Substance Abuse Treatment (CSAT).

Budget

In FY 2010, SAMHSA requests a total of $2,538.9 million for drug control activities, which is an increase of $44.8 million over the FY 2009 level. The Budget directs resources to activities that have demonstrated improved health outcomes and that increase service capacity. SAMHSA has five major drug-related decision units: Substance Abuse Prevention PRNS, Substance Abuse Treatment PRNS, Prescription Drug Monitoring, the Substance Abuse Prevention and Treatment Block Grant, and Program Management. Each is discussed below:

Programs of Regional and National Significance – Prevention

Total FY 2010 Request: $198.3 million
(Reflects $2.7 million decrease from 2009)

CSAP PRNS programs are organized into two categories: 1) Capacity, and 2) Science and Service. Several important drug-related programs within these categories are detailed below.

Prevention Capacity Activities

Capacity activities include service programs, which provide funding to implement service improvement using proven evidence-based approaches, and infrastructure programs, that identify and implement needed systems changes. A major drug-related program included in this category is the Strategic Prevention Framework-State Incentive Grants (SPF-SIGs).

Strategic Prevention Framework State Incentive Grants (SPF SIGs)

FY 2010 Request: $110.0 million
(Reflects no change from FY 2009)

The FY 2009 resources of $110.0 million for SPF SIG support 46 grants to states, tribes, and territories; 4 new Partnerships for Success grants (State and Community Performance Initiative); and several contracts. CSAP's SPF SIG uses a public health approach that supports the delivery of effective programs, policies and practices to prevent substance use disorders. It is an approach that can be embraced by multiple agencies and levels of government that share common goals. It emphasizes developing community coalitions; assessing problems, resources, risk and protective factors; developing capacity in states and communities; implementing evidenced-based programs with fidelity; and monitoring, evaluating, and sustaining those programs. The Partnerships for Success program builds on the success of the SPF SIG program and adds an incentive for grantees that meet state-wide substance abuse prevention targets. Level funding in the FY 2010 Budget reflects continued funding of the SPF SIGs (41 continuation and 6 new) and the *Partnership for Success* grants (4 continuation and 1 new).

Other Prevention Capacity Programs

FY 2010 Request: $61.7 million
(Reflects $2.7 million decrease from 2009)

The FY 2009 Budget includes resources of $64.4 million for existing Mandatory Drug Testing programs, the Substance Abuse Prevention/Minority AIDS grants (SAP/MAI), STOP Act, Methamphetamine grants, Data Coordination and Consolidation Center, and Congressional projects.

FY 2010 Total Changes (-$2.7 million): The FY 2010 level would maintain current contracts and supports 140 HIV/AIDS prevention grants (60 continuation and 80 new). The reduced funding level reflects discontinuation of one-time Congressional projects.

Prevention Science and Service Activities

Science and Service Activities promote the identification and increase the availability of practices thought to have the potential for broad service improvement. A major drug-related program included in this category is the National Registry of Evidence-based Programs and Practices.

National Registry of Evidence-based Programs and Practices

FY 2010 Request: $0.65 million
(Reflects no change from FY 2009)

The FY 2009 resources of $0.65 million will support a share of the cost for the National Registry of Evidence-based Programs and Practices (NREPP). This includes both prevention and treatment. NREPP is a system designed to support informed decision making and to disseminate timely and reliable information about interventions that prevent and/or treat mental and substance use disorders. The NREPP system allows users to access descriptive information about interventions, as well as peer-reviewed ratings of outcome-specific evidence across several dimensions. NREPP provides information to a range of audiences, including service providers, policy makers, program planners, purchasers, consumers, and researchers.

The new NREPP web site provides an array of descriptive information on all reviewed interventions, as well as quantitative ratings (on zero to four scales) for two important dimensions - strength of evidence, and readiness for dissemination. The new web site will also have the capacity to generate customized searches on one or multiple factors including specific types of outcomes, types of research designs, intervention costs, populations and/or settings, as well as the two quantitative dimensions (strength of evidence and readiness for dissemination).

Other Prevention Science and Service Programs

FY 2010 Request: $25.9 million
(Reflects no change from FY 2009)

The FY 2009 Budget provides resources of $25.9 million in support of the Fetal Alcohol Spectrum Disorder program; the Center for the Advancement of Prevention Technologies; the SAMHSA Health Information Network; and Best Practices Program Coordination. The FY 2010 budget continues all of these programs.

Programs of Regional and National Significance – Treatment

Total FY 2010 Request: $458.1 million
(Reflects $45.7 million increase from 2009)

CSAT PRNS programs are also organized into two categories: 1) Capacity, and 2) Science and Service. Several important drug-related programs within these categories are detailed below.

Treatment Capacity Activities

As stated above, capacity activities include services programs, which provide funding to implement service improvement using proven evidence-based approaches, and infrastructure programs, which identify and implement needed systems changes. Key activities included in this category are: Access to Recovery (ATR); Screening, Brief Intervention,

Referral, and Treatment (SBIRT) initiatives; and the Adult, Juvenile, and Family Drug Court treatment services program.

Access to Recovery

FY 2010 Request: $99.0 million
(Reflects no change from FY 2009)

FY 2009 resources for ATR reflect $99.0 million to support the third and final year of funding for the cohort of 24 grants awarded at the end of FY 2007. Within this total, $1.4 million is included to support continuation of the ATR Evaluation, initiated in FY 2008.

ATR is designed to: (1) allow recovery to be pursued through personal choice and many pathways; (2) require grantees to manage performance based outcomes that demonstrate client successes; and, (3) expand capacity by increasing the number and types of providers who deliver clinical treatment and/or recovery support services. The program is administered through state Governor's Offices, recognized Tribal Organizations, or through the Single State Authority overseeing substance abuse activities. ATR uses vouchers, coupled with state flexibility and executive discretion, to offer an opportunity to create positive change in substance abuse treatment and recovery service delivery across the Nation.

In FY 2010, ATR is funded at the same level as FY 2009 to support a new Request for Applications (RFA) for a third cohort (approximately 26 new grants). Individuals that abuse methamphetamine will be included as a priority population in the RFA for the FY 2010 ATR cohort.

Screening, Brief Intervention, Referral, and Treatment Activities

FY 2010 Request: $29.1 million
(Reflects no change from FY 2009)

Substance abuse is one of our Nation's most significant public health challenges. The Screening, Brief Intervention, Referral and Treatment (SBIRT) program has the potential to fundamentally transform substance abuse treatment and prevention in the U.S. The SBIRT approach can intervene early in the disease process before individuals become dependent and/or addicted, and can motivate the addicted to pursue a referral to treatment. This powerful tool can not only prevent the human misery caused by substance abuse but also save millions in health care and treatment costs.

The FY 2009 resources specifically designated for SBIRT activities total $29.1 million, supporting continuation of eight current state grants and contracts. The SBIRT grant program uses cooperative agreements to expand and enhance a state or Tribal Organization's continuum of care by adding screening, brief intervention, referral, and treatment services within general medical settings. In addition, by providing consistent linkages with the specialty treatment system, the SBIRT approach results in systems and policy changes that increase substance abuse treatment access in both the generalist and specialist sectors. Also in FY 2009 continuation funding was provided for the eleven grants awarded in FY 2008 for SBIRT training in selected Medical Residency programs.

The FY 2010 Budget funds SBIRT at the same level as the previous year, $29.1 million. All existing state grants, Medical Residency grants, and associated evaluation and technical assistance contracts will be continued.

Adult, Juvenile, and Family Drug Courts

FY 2010 Request: $58.9 million
(Reflects $35.0 million increase from 2009)

The FY 2009 resources of $23.9 million will support efforts to combine the sanctioning power of courts with effective treatment services to break the cycle of child abuse/neglect, criminal behavior, in addition to alcohol and/or drug abuse. Included within this amount is $11.7 million in funding for award of approximately 40 new grants. The purpose of Adult, Juvenile, and Family Drug Court grants is to supply funds to treatment

providers and the courts to provide alcohol and drug treatment, wrap-around services supporting substance abuse treatment, assessment, case management, and program coordination to those in need of treatment drug court services. Priority for the use of the funding will be given to addressing gaps in the continuum of treatment.

FY 2010 Total Changes (+$35.0 million): The Adult, Juvenile, and Family Drug Court treatment services program includes an increase of $35.0 million to support award of approximately 100 new drug court grants. Included within this amount is $5.0 million for a program to address the needs of children of methamphetamine users by providing case management assistance to link them with appropriate services.

Offender Reentry Program

FY 2010 Request: $23.2 million
(Reflects $15.0 million increase from 2009)

Over the past decade, awareness of the need for a continuing care system for juvenile and adult offenders has grown as states and local communities have struggled with an increasing number of these individuals returning to the community after release from correctional confinement. SAMHSA has funded young offender programs for several years, and $8.2 million is included in the FY 2009 Budget for offender reentry grants that will serve both adult and juvenile offenders.

FY 2010 Total Changes (+$15.0 million): To further address this population in FY 2010, an increase of $15.0 million will support an additional offender reentry cohort of grants that will provide substance abuse treatment and recovery support services to adult and juvenile offenders returning to society from incarceration. Approximately 29 new grants are expected to be awarded.

Other Treatment Capacity Programs

FY 2010 Request: $220.9 million
(Reflects $4.3 million decrease from 2009)

The FY 2009 Budget includes resources of $225.2 million for several other Treatment Capacity programs including: Treatment Systems for Homeless; the Minority AIDS Initiative, Opioid Treatment Programs and Regulatory Activities; Children and Families, and Services Accountability, as well as others.

FY 2010 Total Changes (-$4.3 million): The FY 2010 Budget includes funds for continuing grants and contracts in the various programs, and reflects discontinuation of one-time Congressional projects.

Treatment Science and Service Activities

As stated above, Science and Service Activities promote the identification and increase the availability of practices thought to have the potential for broad service improvement. A major drug-related program included in this category is the Addiction Technology Transfer Centers (ATTCs).

Treatment Science and Service

FY 2010 Request: $27.0 million
(Reflects no change from FY 2009)

The FY 2009 Budget includes resources of $27.0 million for Treatment Science and Service programs including: the National Registry of Evidence-Based Programs and Practices (as described in the Prevention section above); the SAMHSA Health Information Network (a jointly-funded effort by all SAMHSA Centers); and the Addiction Technology Transfer Center (ATTC) initiative (a network of fourteen regional activities and a National ATTC Office that support training and technology transfer activities and promotion of workforce development in the addiction treatment field), among others. The FY 2010 budget continues all of these programs at the same funding level as FY 2009.

Prescription Drug Monitoring Program

FY 2010 Request: $2.0 million
(Reflects no change from FY 2009)

Prescription drug abuse continues to be a significant public health problem, with almost seven million people over the age of 12 indicating current non-medical use of pain relievers, tranquilizers, sedatives, and stimulants (National Survey on Drug Use and Health, 2007). To address this problem, the FY 2009 budget includes $2 million for SAMSHA to implement the National All Schedules Prescription Electronic Reporting Act of 2005 ("NASPER" P.L. 109-60). Under this program, formula grants will be awarded to eligible states to foster the establishment or enhancement of state-administered controlled substance monitoring systems, ensuring that health care providers and law enforcement officials have access to accurate, timely prescription history information. The expansion and establishment of prescription monitoring systems has the potential for assisting in early identification of patients at risk for addiction, and early identification will lead to enhanced substance abuse treatment interventions. The FY 2010 Budget continues the NASPER program at the same level as FY 2009.

Substance Abuse Prevention and Treatment (SAPT) Block Grant

FY 2010 Request: $1.779 billion
(Reflects no change from FY 2009)

The overall goal of the SAPT Block Grant is to support and expand substance abuse prevention and treatment services, while providing maximum flexibility to states. States and territories may expend their funds only for the purpose of planning, carrying out, and evaluating activities related to these services. States may provide SAPT Block Grant funds to community and faith-based organizations to provide services. Of the amounts appropriated for the SAPT Block Grant, 95 percent are distributed to states through a formula prescribed by the authorizing legislation. Factors used to calculate the allotments include total personal income; state population data by age groups (total population data for territories); total taxable resources; and a cost of services index factor. Remaining funds are used for data collection, technical assistance, and program evaluation, which are retained by SAMHSA for these purposes. The set-aside is distributed among CSAP, CSAT, and the SAMHSA Office of Applied Studies for purposes of carrying out the functions prescribed by the SAPT Block Grant legislation.

The FY 2009 resources of $1.779 billion will provided grant awards to 60 eligible states, territories, the District of Columbia, and the Red Lake Band of Chippewa Indians in Minnesota. These resources will support approximately 2 million treatment episodes. The SAPT Block Grant program in FY 2010 is funded at the same level as FY 2009, and will provide support to the current 60 jurisdictions for a similar level of prevention and treatment services.

Program Management

FY 2010 Request: $101.9 million
(Reflects $1.8 million increase from 2009)

The FY 2009 resources of $100.1 million support staffing and activities to administer SAMHSA programs. Program Management supports the majority of SAMHSA staff who plan, direct, and administer agency programs and who provide technical assistance and program guidance to states, mental health and substance abuse professionals, clients, and the general public. Agency staffing represents a critical component of the budget. There are currently 57 members of the SAMHSA staff who provide direct state technical assistance and are funded through the 5% Block Grant set-asides. Program Management also includes: contracts for block grant investigations (monitoring); support for the Unified Financial Management System (UFMS); administrative activities such as Human Resources, Information Technology, and centralized services provided by the Program Support Center and the Department of Health and Human Services.

FY 2010 Total Changes (+$1.8 million): The FY 2010 Budget includes a $1.8 million increase for pay and administrative costs.

Performance

Introduction

This section on the FY 2008 performance of SAMHSA programs is based on agency GPRA documents and OMB reviews. The tables include performance measures, targets, and achievements for the latest year for which data are available.

The Substance Abuse Treatment Programs of Regional and National Significance (PRNS) were reviewed in 2002 with a rating of "Adequate." In 2003, the Substance Abuse Prevention and Treatment Block Grant was given a rating of "Ineffective." The Substance Abuse Prevention PRNS was rated "Moderately Effective" in 2004 as was the Access to Recovery Program in 2007.

Over the past several years, SAMHSA, in collaboration with the states, has identified a set of standardized National Outcome Measures (NOMs) that will be monitored across all SAMHSA programs. The NOMs have been identified for both treatment and prevention programs, as well as common methodologies for data collection and analysis.

SAMHSA has implemented on-line data collection and reporting systems for prevention and treatment programs, and has assisted states in developing their data infrastructures. Efficiency measures have also been implemented for all programs.

CSAP

The major programs are the 20 percent prevention set-aside from the SAPT Block Grant and PRNS, discussed in the following sections.

The SAPT Block Grant – Prevention 20% Set Aside

CSAP SAPT 20% Prevention Set Aside		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Actual**
» Percent of States showing an increase in State-level estimates of survey respondents who rate the risk of substance abuse as moderate or great (age 12-17)	Identify baseline	45.1%
» Percent of States showing a decrease in State-level estimates of survey respondents who report 30-day use of alcohol (age 12 - 20)*	Baseline	51%
» Percent of States showing a decrease in State-level estimates of survey respondents who report 30-day use of other illicit drugs **	Baseline	52.9%
» Number of participants served in prevention programs	17,482,060	25,258,287

* Percent, ages 12-20, who report they have used alcohol in the last 30 days.

**Percent, ages 12-17, who report they have used illicit drugs in the last 30 days.

Discussion

In previous years, population-based measures taken from the National Survey on Drug Use and Health (NSDUH) have been used as proxy measures for the 20% set-aside. Since they do not reflect change at a grantee level, they have been retired and replaced with separate measures reflecting the percentage of states improving, based on state-level estimates from the NSDUH. Baseline data for FY 2008 have been identified for these new measures and targets set for FY 2009. The target for the number of participants served for FY 2008 was exceeded substantially.

States are placing an increased emphasis on applying the strategic prevention framework (SPF) to the use of SAPT funds. For example, 51 states and territories now use SPF or the equivalent for conducting needs assessments, 53 for building state capacity, 53 for planning, 43 for program implementation, and 29 states for evaluation efforts.

For example, in Illinois, the Illinois Commission on Children and Youth is working to develop a 5-year strategic plan for providing services to children, youth, and young adults. This will enhance coordination of existing state programs and services and develop strategies related to preventive health, education completion, workforce development, social and emotional development, and civic engagement. California's Statewide Needs Assessment and Planning (SNAP) project will implement a systematic, recurring process to support ongoing state and county needs assessment and planning. The SNAP project will be consistent with ADP's Strategic Plan and is guided in part by SAMHSA's SPF. Michigan's Office of Drug Control Policy (ODCP) contracts with regional coordinating agencies which have revised local-level prevention program planning—funded by the Block Grant—by adopting the SPF-SIG five-step planning model.

CSAP PRNS

CSAP PRNS		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» Percent SPF SIG states with decrease in 30-day use of illicit drugs (ages 12-17)*	61.5%	55.9%
» Percent SPF SIG states with increase in perception of risk from substance abuse (age 12-17).	80.9%	50%
» HIV: Percent of participants who rate the risk of substance abuse as moderate or great (age 12-17)	75.8%	TBR August 2009
» HIV: Percent of participants who used illicit drugs at pre-test who report a decrease in 30-day use at post-test (age 18 and up)	69.2%	TBR August 2009

* SPF SIGs are Strategic Prevention Framework State Incentive Grants.

Discussion

The Prevention PRNS programs primarily focus on the Strategic Prevention Framework State Incentive Grants (SPF SIG) and the Minority Substance Abuse/HIV Prevention Initiative.

The SPF SIG takes a public health approach for the prevention of substance abuse by requiring a systematic, comprehensive, prevention process, first at the state and then at the community level. This state and community infrastructure and capacity building is expected to have stronger and longer lasting effects over time. The SPF SIG grantees failed to meet their targets, although they met their targets for some of the other measures. These failures reflect a variety of methodological and statistical issues. SPF SIG grantees are required to go through multiple stages of the SPF process before they begin implementing services. These initial steps lead to a lag between the time the grants are awarded and community change is observable. Also, there is lag time in the availability of NSDUH data used to populate these measures. The data used to determine the percent of states improving on each measure are from 2004/2005 and 2005/2006. Since the initial Cohort 1 grantees were funded in 2005, these data cannot reflect actual SPF SIG impacts. Lastly, state-level percentages of use and non-use are affected by numerous factors external to prevention programs, such as state-level demographic and socioeconomic changes.

The goal of the HIV 6-cohort program is to increase the capacity of communities serving the target populations to deliver evidence-based substance abuse prevention, HIV and hepatitis prevention services. This program was redesigned to incorporate the Strategic Prevention Framework model and began in FY 2007. Given these substantial program changes, we have established baselines for new measures focusing on pre/post data on clients who have participated in prevention interventions lasting at least 30 days. Each client is followed up from program entry to program exit and to 3 to 6 months thereafter. FY 2008 actuals will be reported in August 2009 following the complete online submission of grantee data and review, correction, and analysis of data by CSAP.

CSAT

The major programs are the SAPT Block Grant and the PRNS, described in the following sections.

The SAPT Block Grant – Treatment

CSAT SAPT Block Grant		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» Percent clients reporting abstinence from drug use at discharge	69%	TBR Nov 2009
» Number of admissions to substance abuse treatment programs receiving public funding *	1,881,515	TBR Oct 2010

*Data source since FY 2007 is SAMHSA's Web Block Grant Application System.

Discussion

SAMHSA has established a data-driven block grant mechanism which will monitor the new National Outcome Measures (NOMs) as well as improve data collection, analysis, and utilization. Data for the treatment NOMs are drawn from a combination of sources, including the Treatment Episode Data Set and state-specific reports. A major milestone was reached when the reporting of NOMs was made mandatory in the FY 2008 SAPT Block Grant Application. In addition, findings from a national evaluation of the Block Grant program will be available later this year.

Data on FY 2008 achievements are not yet available. However, for FY 2007, the Block Grant program exceeded their target (2,003,324) for the number of clients served, serving a total of 2,372,302 clients. At discharge, 81% of clients had abstained from alcohol, 74% had abstained from drug use, 43% were employed, and 89% reported having no involvement with the criminal justice system.

CSAT PRNS

CSAT PRNS		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» Percent of adult clients currently employed/engaged in productive activities	52%	54%
» Percent of adult clients with permanent place to live	51%	47%
» Percent of adult clients with no involvement with the criminal justice system	96%	96%
» Percent of adult clients with no/reduced alcohol or illegal drug-related health, behavioral, or social consequences	67%	68%
» Percent adult clients with no past-month substance abuse	63%	62%
» Number of clients served*	35,334	33,446

*Total of all CSAT Capacity programs excluding Access to Recovery and the Screening, Brief Intervention, Referral, and Treatment program.

Discussion

The Treatment PRNS provides funding to implement service improvements, using proven evidence-based approaches, system changes, and programs to promote identification and increase the availability of practices with potential for broad service improvement. The PRNS enables CSAT to address emerging issues in the field. CSAT staff routinely monitors grantees' progress to ensure that program goals and objectives are being met.

In 2008 the PRNS programs did not meet their target (35,334) for the number of clients served – total number served was 33,446. The programs did achieve an abstinence level of 62%, an employment level of 54%, a housing level of 47%, and a level of 96% for clients having no involvement with the criminal justice system at six-month follow-up.

Among the PRNS programs is the Screening, Brief Intervention, Referral, and Treatment program (SBIRT), implemented in 2003. In FY 2008, SBIRT provided over 190,000 substance abuse screenings in primary and generalist settings. CSAT also completed the design for an evaluation of the program. In 2008, data collection took place for the national evaluation. The evaluation team has begun preliminary data analysis. Finally, targets for employment and criminal justice involvement were met or exceeded.

Access to Recovery

Access to Recovery		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» Percentage of individuals receiving services who had no past month substance use	80%	82.3%
» Percentage of individuals receiving services who had improved family and living conditions	52%	52.9%
» Percentage of individuals receiving services who had no involvement with the criminal justice system	96%	96%
» Percentage of adults receiving services who had improved social support	90%	91.7%
» Percentage of individuals receiving services who are currently employed or engaged in productive activities	53%	59.1%
» Average cost per client through ATR	$1,605	$1,888
» Number of clients gaining access to treatment	30,000	50,845

Discussion

The Access to Recovery (ATR) program provides grants to states, tribes, and tribal organizations to undertake voucher programs that expand substance abuse treatment capacity and promote choice among clinical treatment and recovery support providers.

In 2008 the ATR program exceeded its target for the number of clients served, serving 50,845 clients compared to the target of 30,000. In total, over 260,000 clients have been served since inception. Moreover, the program's achievements include a number of positive developments measured at the time of discharge: an abstinence level of 82%, an employment level of 59%, an improved social support level of 92%, and a level of 96% of clients having no involvement with the criminal justice system.

Substance Abuse Drug Courts

Substance Abuse Drug Courts		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» Percentage of juvenile clients receiving services who had a permanent place to live in the community	81%	81%
» Percentage of juvenile clients that complete treatment	74%	75.1%
» Percentage of juvenile clients receiving services who had no involvement with the criminal justice system	92%	94.3%

Discussion

The Treatment Drug Court program provides funding to address the treatment needs of substance using individuals involved in a Drug Court. The Program is designed to provide holistic treatment and wrap-around services to criminally-involved substance-using individuals in order to assist them in achieving and maintaining abstinence from substance use along with improving their overall quality of life.

The Juvenile Drug Court Program demonstrated successful results in 2008, meeting or exceeding targets related to housing, treatment completion, and criminal justice involvement.

The Adult Drug Court Program is discussed in the Department of Justice – Office of Justice Programs section of the FY 2010 Budget Summary.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institute on Drug Abuse

Resource Summary

	Budget Authority (in Millions)		
	FY 2008 Final	FY 2009 Enacted	FY 2010 Request
Drug Resources by Function			
Prevention	$412.936	$423.911	$429.093
Treatment	593.086	608.848	616.291
Total Drug Resources by Function	**$1,006.022**	**$1,032.759**	**$1,045.384**
Drug Resources by Decision Unit			
National Institute on Drug Abuse	$1,006.022	$1,032.759	$1,045.384
Total Drug Resources by Decision Unit	**$1,006.022**	**$1,032.759**	**$1,045.384**

Drug Resources Personnel Summary			
Total FTEs (direct only)	376	384	392
Drug Resources as a Percent of Budget			
Total Agency Budget (in billions)	$1.006	$1.033	$1.045
Drug Resources Percentage	100.00%	100.00%	100.00%

Program Summary

Mission

Over the past three decades, research supported by the National Institute on Drug Abuse (NIDA) has revolutionized our understanding of addiction as a chronic, relapsing brain disease—knowledge that is helping to correctly situate addiction as a serious public health issue and to frame how we ultimately treat this disease. New knowledge is revealing an increasingly detailed picture of the molecular, cellular, and circuit level changes that can lead to compulsive drug use and addiction.

By supporting research that reveals how drugs affect the brain and behavior and how multiple factors influence drug abuse and its consequences, including HIV, NIDA is advancing effective strategies to prevent people from ever using drugs and to treat them when they cannot stop. NIDA continues to carry out its mission "to lead the Nation in bringing the power of science to bear on drug abuse and addiction." Our portfolio reflects a comprehensive approach aimed at developing knowledge that can transform the way we prevent and treat drug abuse and addiction, and that can be translated into the clinic and the community.

Budget

In FY 2010, NIDA requests $1.045 billion, which is an increase of $12.6 million from the FY 2009 enacted level. NIDA's support of science has generated knowledge, including knowledge used

to develop prevention interventions that have helped contribute to the declines in both licit and illicit drug use, particularly among our Nation's youth. NIDA's 2008 national Monitoring the Future (MTF) Survey reports a 25-percent decline in illicit drug use among 8th, 10th, and 12th graders combined, between 2001 and 2008, with cigarette smoking at its lowest rate since the survey began in 1975. Still, drug abuse and addiction remain highly prevalent, and changes in the drug culture require vigilance to curtail their spread. Particularly worrisome is the non-medical use of prescription and over-the-counter medications, most severe for opiate analgesics (e.g., hydrocodone and oxycodone). Abuse of these drugs rose throughout the 1990s and has remained stubbornly steady among adolescents during recent years, surpassed only by marijuana in rates of abuse.[1] NIDA diligently supports research to understand causal factors and to spur the development of responsive and effective prevention approaches.

Another overarching challenge is how to deliver treatment to those who need it, most of whom go without. Thus, we remain committed to translating research for use in community settings through support of effectiveness research, including our National Drug Abuse Treatment Clinical Trials Network (CTN) and Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS), and through educational outreach to judges, physicians, treatment providers, single state authorities, and other stakeholders.

New Tools, New Opportunities

We now have more sensitive and less costly tools to identify the genetic variations that increase vulnerability for addiction and related health consequences. Recent genome-wide association studies of nicotine addiction, for example, have pointed to previously unsuspected genes whose products may be involved in the addiction process and in the susceptibility to smoking-related diseases, such as lung cancer and peripheral arterial disease. Knowledge gleaned from genetics research will not only help identify predictors of disease vulnerability, but will optimize treatments by including a patient's genetic profile which, ideally, will result in more efficacious and cost-effective strategies.

To complement these efforts, NIDA is investing in the rapidly evolving field of epigenetics, which focuses on the lasting modifications to DNA structure and function from exposure to various stimuli (e.g., parenting quality, stress, diet, drugs, etc.). A better understanding of how to exploit epigenetic changes to reduce vulnerability or counter the effects of abuse and addiction could result in unprecedented opportunities to enhance addiction treatment efficacy. While these genetic and epigenetic tools will greatly expand our ability to predict addiction risk and treatment success, new research designed to develop a comprehensive panel of addiction biomarkers could produce an addiction "signature" that could be used to assess chronic exposure to drugs and to monitor the effects of a given course of therapy.

Other emerging opportunities are found in interventions using web- and computer-based technologies, which have produced positive outcomes for drug abuse and HIV risk behaviors. NIDA-supported research will continue to investigate how such interactive technology can be integrated into the addiction treatment system to improve its effectiveness and bring about more widespread adoption of evidence-based approaches.

Partnering with Physicians and the Health System

Physicians can be the frontline for identifying patients who are abusing drugs that may put their health at risk even *before* problems arise. Thus,

[1]Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2008). *Monitoring the Future national survey results on drug use, 1975-2007. Volume I: Secondary school students* (NIH Publication No. 08-6418A). Bethesda, MD: National Institute on Drug Abuse, 707 pp.

NIDA is set to disseminate a web-based "toolkit" to help physicians screen their patients for abuse of licit and illicit substances, including prescription drugs, and refer them to treatment. NIDA also continues to support research on the impact and cost effectiveness of physician screening, brief intervention, and referral to treatment (SBIRT) for substance abuse.

The development of new medications may also serve to engage physicians more fully. Indeed, medications development is a crucial component of NIDA's research portfolio, particularly as efforts to engage the private sector have been met with limited success because of perceived financial disincentives and addiction-related stigma. Advances in our understanding of addiction neurobiology are revealing new molecules and structures that could be targets for addiction therapies. These include medications aimed at methamphetamine and cannabis addiction; vaccines for cocaine, nicotine, heroin, and methamphetamine addiction; pain medications without addictive liability; and new entities based upon recently identified candidate receptors or receptor combinations.

New Strategies in the Fight against HIV/AIDS and Drug Abuse

Drug use and HIV are inextricably linked—intravenous use is responsible for roughly one-third of HIV infections in this country since the epidemic began, and prevalence rates among non-injection drug users can be just as high. NIDA therefore supports research aimed at reducing HIV transmission, including finding innovative ways to incorporate HIV education, testing, counseling, and treatment referral in community settings, and overcoming barriers, such as stigma and inadequate access to HIV and drug abuse treatment. Our research also aims to learn more about the neurological complications of HIV and substance abuse and their treatments so as to develop more integrative and responsive counter interventions. To attract innovative scientists, NIDA created an Avant-Garde award for high-impact research likely to foster groundbreaking approaches to prevent and treat HIV/AIDS in drug abusers. NIDA also continues to target HIV/AIDS-related health disparities and integrate HIV/AIDS initiatives worldwide.

National Institute on Drug Abuse

Total FY 2010 Request: $1.045 billion[2]
(Reflects $12.6 million increase from FY 2009)

Basic and Clinical Neuroscience and Behavioral Research

Total FY 2010: $491 million
(Reflects $5.6 million increase from FY 2009)

Basic and Clinical Neuroscience and Behavioral Research represent two programs in NIDA that work together to enlarge understanding of the neurobiological, genetic, and behavioral factors underlying drug abuse and addiction. Specifically, they examine the factors affecting increased risk and/or resilience to drug abuse, addiction, and drug-related disorders; the mechanisms of addiction; and the effects of drugs on the brain and behavior. To see these effects in real time, NIDA researchers are increasingly integrating brain imagining tools like functional magnetic resonance imaging (fMRI) into their studies. This may facilitate the development of novel treatments for addiction using "neurofeedback" (i.e., training patients to influence brain activation at specific sites) and will allow the examination of less-studied brain circuits, such as those involved with interoception (internal monitoring of bodily functions and sensations) linked with emotion and motivation. A greater understanding of interceptive processing may lead to new targets for treatment research to reduce a patients' risk of relapse to substance abuse. Another emerging research area is epigenetics—the study of long-term changes in gene function that result from environmental impacts, such as drug exposure, maternal behavior, and stress. This is the focus of

[2] *Includes $13.2 million for NIH Roadmap research*

a key *Common Fund* initiative that NIDA co-leads with the National Institute on Deafness and Other Communication Disorders and the National Institute of Environmental Health Sciences. Collectively, this research provides the fundamental information to develop and inform prevention and treatment interventions for drug abuse and addiction.

FY 2010 Total Changes +$5.6 million): The 2010 estimate for this program area is $491.0 million, an increase of $5.6 million above the FY 2009 enacted level. By applying funds from grants that are ending in FY 2008, we will pursue opportunities in line with our top priorities, one of which is to explore gene x drug interactions to better identify addiction vulnerability. A FY 2009 RFA will leverage a collaborative arrangement between geneticists and behavioral pharmacologists to study the relationship between individual variations in drug abuse/addiction–related behaviors and genetic polymorphisms identified through model organism approaches and genome wide association studies. Results should yield a rich characterization of gene x drug interactions and vulnerability phenotypes across a variety of behavioral measures related to drug abuse. Another FY 2009 RFA will solicit research that combines genetics and neuroimaging technologies to help us understand the variability of brain dysfunction in drug abusers.

Epidemiology, Services and Prevention Research

FY 2010: $246.1 million
(Reflects $2.8 million increase from FY 2009)

This major program area seeks to promote integrated approaches to understand and address the interactions between individuals and environments that contribute to the continuum of drug abuse–related problems. The vision is to support research and major data collection systems and surveillance networks to help identify substance abuse trends locally, nationally, and internationally; to guide development of responsive interventions for a variety of populations; and to encourage optimal service delivery in real-world settings.

By mining our National Monitoring the Future Survey of youth, a robust correlation was discovered between regular exercise in 12th graders and lower prevalence rates of daily cigarette smoking or marijuana use in the past month. Spurred in part by this compelling finding, NIDA-sponsored a science meeting in June 2008, entitled "Can Physical Activity and Exercise Prevent Substance Use: Promoting a Full Range of Science to Inform Prevention." The meeting allowed scientists to share relevant research findings addressing the relationship between physical activity/exercise and behavioral health. NIDA has since issued a call for studies on physical activity and drug abuse prevention, which will include basic, clinical, and services research.

FY 2010 Total Changes +$2.8 million): The 2010 estimate for this program area is $246.1 million, an increase of $2.8 million above the FY 2009 enacted level. A major focus for this NIDA program area is to improve drug abuse prevention and treatment services among populations at particular risk. For example, through a FY 2009 program announcement, NIDA will support targeted research on the association between drug abuse and deployment stress and combat trauma among U.S. military personnel and their families. Exposure to combat has been associated with increased substance abuse risk, as well as post traumatic stress and depressive disorders and disrupted social relationships. NIDA is also reaching out to major academic health centers that are part of the Clinical and Translational Science Awards (CTSA) consortium to ensure that drug abuse research is an integral component of this effort. This consortium will eventually join together 60 institutions to energize the clinical and translational science field. NIDA's goal, supported by a FY 2009

program announcement, is to encourage the integration of substance abuse prevention, screening, and treatment research into the CTSA programs.

Pharmacotherapies and Medical Consequences

FY 2010 Request: $118.5 million
(Reflects $1.4 million increase from FY 2009)

This program area is responsible for medications development aimed at helping people recover from drug abuse and addiction and sustain abstinence. Capitalizing on research showing the involvement of different brain systems in drug abuse and addiction—beyond the dopamine system—NIDA's medications development program is pursuing a variety of newly defined targets and treatment approaches. This program area also seeks solutions addressing the medical consequences of drug abuse and addiction, including infectious diseases such as HIV. NIDA is exploring several areas with exciting implications for the future. These include individualized treatments based on a person's genetic makeup, new mechanisms for restoring an addicted person's capacity to appreciate natural rewards in lieu of drugs, and pharmacotherapies that use an immunization strategy to help prevent relapse to drugs, with cocaine and nicotine vaccines now undergoing safety and efficacy testing, respectively, in humans.

FY 2010 Total Changes (+$1.4 million): The FY 2010 estimate for this program area is $118.5 million, an increase of $1.4 million above the FY 2009 enacted level. Program plans for FY 2010 give highest priority to facilitating medications development for patients addicted to multiple substances of abuse, licit and illicit. To this end, a FY 2009 PAS will encourage clinical trials to test innovative uses of already approved medications, as well as preclinical studies to test novel compounds for treating polydrug addiction. NIDA will continue to stimulate research for the design, synthesis, and pharmacological evaluation of new classes of compounds as potential treatments for nicotine, cocaine, methamphetamine, or cannabis addiction, as well as conduct pilot clinical trials of potential medications for substance related disorders.

NIDA will also issue a program announcement for research to improve strategies for treating opiate addiction worldwide. Heroin addiction, and intravenous drug use specifically, continues to drive the HIV/AIDS epidemic in a number of countries resistant to using the currently approved medications for opioid addiction. Thus, building on the promise of the nicotine vaccine, now in commercial development, NIDA is investing in the development of a heroin vaccine. NIDA is also encouraging implementation research to optimize the use of effective drug treatment modalities internationally, including long-acting medications, such as depot naltrexone (an opioid antagonist).

Clinical Trials Network

FY 2010 Request: $42.0 million
(Reflects $0.5 million increase from FY 2009)

NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN), which now comprises 16 research nodes and more than 240 individual community treatment programs, serves 34 states, plus the District of Columbia and Puerto Rico. The CTN tests the effectiveness of new and improved interventions in real-life community settings with diverse populations. It also serves as a research and training platform to help NIDA respond to emerging public health areas. Currently, the CTN provides a research platform for more than 30 research grants and a training platform for 60+ research fellows and junior faculty. Upcoming activities include plans to evaluate the potential value of exercise as an add-on to inpatient treatment for substance abusers, and a clinical trial to assess the relative effectiveness of various HIV testing strategies in

reducing risky sexual and drug-related behaviors. Finally, in the wake of encouraging results in 2008 on the application of "Positive Choice", an interactive, patient-tailored computer program to improve clinic-based assessment and counseling for risky behaviors, NIDA is also planning to support the development of web-based training on addiction medicine for pain management providers.

FY 2010 Total Changes (+$0.5 million): The FY 2010 estimate for this program area is $42.0 million; an increase of $482,000 above the FY 2009 enacted level. Program plans, along with expected accomplishments, are a continuation of initiatives begun in FY 2008 to (1) assess the effectiveness of a 12-step facilitation intervention for stimulant abusing patients in initiating and sustaining their involvement with support groups like Cocaine or Alcoholics Anonymous, (2) determine whether adding individual drug counseling to buprenorphine/naloxone (BUP/NX) treatment, along with Standard Medical Management (SMM), improves outcomes for patients addicted to pain medications, and (3) compare the effect of BUP/NX versus methadone on liver enzymes in patients entering opioid treatment programs, a phase 4 study requested by the FDA to provide additional information on risks, benefits, and optimal use of these medications.

Intramural Research Program

FY 2010 Request: $87.6 million
(Reflects $1.3 million increase from FY 2009)

This Intramural research program (IRP) performs cutting edge research within a coordinated multidisciplinary framework. The IRP attempts to elucidate the nature of the addictive process; to determine the potential use of new therapies for substance abuse, both pharmacological and psychosocial; and to decipher the long-term consequences of drugs of abuse on brain development, maturation, function, and structure, and on other organ systems. Recent IRP activities include the conduct of basic research to understand the role of mitochondria—the "powerhouse" of a cell that breaks down glucose to release energy—in degenerative neurological diseases (e.g., Parkinson's disease). IRP activities also use a variety of animal models of addiction to better understand the effects of drugs on brain and behavior. In addition, the IRP supports an HIV/AIDS Pathophysiology and Medications Discovery Program, which focuses on (1) how HIV or its products cross the blood-brain barrier, (2) how toxic compounds generated by HIV invade brain cells, and (3) the development of compounds to block the toxic effects of HIV on immune system cells.

FY 2010 Total Changes (+$1.3 million): The FY 2010 estimate for this program area is $87.6 million, an increase of $1.3 million above the FY 2009 enacted level. NIDA plans to take advantage of new and emerging techniques, including new tools to measure the effect of psychosocial stress on individuals with substance-use disorders by collecting behavioral and physiological data in participants' real time environments. This activity represents the first systematic, prospective effort to link indices of community-level risk to intensive field measurements of individual attempts at behavior change.

Research Management and Support (RMS)

FY 2010 Request: $60.1 million
(Reflects $1.0 million increase from FY 2009)

RMS activities provide administrative, budgetary, logistical, and scientific support in the review, award, and monitoring of research grants, training awards, and research and development contracts. Additionally, the functions of RMS encompass strategic planning, coordination, and evaluation of NIDA's programs, regulatory compliance, international coordination, and liaison with other Federal agencies, Congress, and the public. NIDA currently oversees more than 1,800 research grants

and more than 190 research and development contracts.

In addition to the infrastructure required to support research and training, NIDA also strives to educate the public about drug abuse and addiction and to raise awareness of the science behind it. In October 2008, NIDA held its second Drug Facts Chat Day, following an overwhelming response the year before, to again give students and teachers across the country the chance to interact with NIDA staff via the Internet on questions about drugs' effects on the brain and body, and a variety of other issues related to addiction and treatment. NIDA also strives to encourage young people interested in careers in science. This year NIDA co-sponsored an Addiction Science award given at the Intel International Science and Engineering Fair to the top three projects advancing addiction science. The winners offered impressive and innovative approaches to exploring some of the neurological and environmental underpinnings of addiction. This premier event was followed by an in-person visit to NIDA and NIH by the top winners, who presented their findings to staff and to Dr. Zerhouni.

FY 2010 Total Changes (+$1.0 million): The FY 2010 estimate for this program area is $60.1 million, an increase of $1.0 million above the FY 2009 enacted level. NIDA will continue to support scientific meetings to stimulate interest and develop research agendas in areas significant to drug abuse and addiction. These meetings, as well as input from the NIDA Director, the National Advisory Council on Drug Abuse, NIDA Staff, Program Experts, and Constituent Organizations, have been critical to the development of NIDA's new 5-year Strategic Plan. The plan outlines major goals that will guide NIDA's research agenda for the future. NIDA will also continue to support educational outreach aimed at diverse audiences, including the general public, HIV high-risk populations, physicians, judges, and educators to help raise awareness of substance abuse issues and disseminate promising prevention and treatment strategies.

Performance

Introduction

This section on NIDA's FY 2008 performance is based on agency GPRA documents and the OMB review. The table includes performance measures, targets, and achievements for the latest year for which data are available.

In calendar years 2003 through 2006 NIDA programs were included in OMB reviews of the following NIH programs: HIV/AIDS Research, Extramural Research Programs, Intramural Research Programs, and the NIH Research Training and Research Career Development Program. The HIV/AIDS portfolio and Extramural Construction were found to be Moderately Effective; the Buildings and Facilities, Extramural and Intramural Programs, and the Extramural Research Training and Research Career Development activities were found to be Effective.

To ensure adequate representation of NIH's commitment to the best possible research and coordination of research efforts across NIH, the goals articulated are representative of NIH's broad and balanced portfolio of research. Goals, therefore, are not Institute-specific; rather, they are trans-NIH – comprising lead Institutes and contributors. This approach ensures adequate representation of NIH's commitment to the best possible research and coordination of research efforts across NIH. NIDA also contributes to the HHS Strategic Plan Goal 4: Scientific Research and Development.

NIDA continues to participate in a number of trans-NIH scientific research outcome (SRO) goals. One of these goals is indicative of NIDA's efforts in the prevention and treatment of drug

abuse and addiction. NIDA participates in SRO 3.5, which states, "By 2013, identify and characterize at least 2 human candidate genes that have been shown to influence risk for substance use disorders and risk for psychiatric disorders using high-risk family, twin, and special population studies." By identifying genetic factors involved in the various stages of the addiction process, this goal is intended to aid in the development of improved primary (stop drug use before it starts) and secondary (prevent relapse) prevention programs.

In addition to SRO 3.5, NIDA completed SRO 4.5.5 in FY 2008. NIDA was the lead Institute on SRO 4.5.5, which states, "By 2008, develop and test two new evidence-based treatment approaches for drug abuse in community settings." This goal is intended to bring more drug addiction treatments from "bench to bedside." In FY 2009, NIDA will replace SRO 4.5.5 with SRO 8.7, which states "By 2012, identify three effective implementation strategies that enhance the uptake of research-tested interventions in service systems such as primary care, specialty care and community practice." By studying treatment implementation, this goal is intended to improve the translation of research into practice. Like SRO 4.5.5, SRO 8.7 is indicative of NIDA's efforts to more broadly bring evidence-based treatments for drug addiction to the people who need them.

National Institute on Drug Abuse		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» SRO -3.5, by 2013, identify and characterize at least 2 human candidate genes that have been shown to influence risk for substance use disorders and risk for psychiatric disorders using high-risk family, twin, and special population studies	Identify genomic markers that differ in addicted individuals who respond to treatment versus those who do not.	SNP analyses identified a gene cluster predictive of treatment response to bupropion for smoking cessation and revealed additional genetic markers of addiction vulnerability.
» SRO -4.5.5, by 2008, develop and test two new evidence-based treatment approaches for drug abuse in community settings	Complete goal of developing and testing of two new evidence-based treatment approaches for drug abuse in community settings	Research has been completed on two treatments for drug abuse (MET and Seeking Safety), and final analyses are underway on a third treatment (BSFT) developed and testing in community settings.

Discussion

NIDA is a lead contributor toward NIH's scientific research goal of developing and testing evidence-based treatment approaches for specialized populations in community treatment settings. Using the National Drug Abuse Treatment Clinical Trials Network that NIDA established in 1999, NIDA met the FY 2008 target by completing research on two treatments for drug abuse (MET and Seeking Safety). Final analyses are under way on a third treatment (BSFT) that has been developed and tested in community settings.

Results from a multi-site clinical trial of MET in community drug abuse clinics showed sustained substance use reductions only among primary alcohol users. Other findings from the research demonstrated that: (1) training in Motivational Interviewing (MI) increases proficiency in its implementation; (2) the combination of expert-led workshops followed by program-based clinical supervision is an effective method for disseminating motivational interventions in treatment programs; (3) having active MI supervisory capacity and a champion for the intervention in the clinic increases its adoption; and (4) there are opportunities in the early stages of treatment for implementing motivational therapies to improve standard clinical practice and patient outcomes.

Research was completed in community treatment settings on the Seeking Safety protocol, an intervention developed for women with post traumatic stress disorder (PTSD). Results were that integrated treatment for PTSD and substance use disorders had a significant impact on trauma symptoms, but did not improve substance abuse outcomes more than the control condition. Seeking Safety also had a positive effect on sexual risk behaviors (decreased) and did not increase adverse events, such as substance use and its related consequences. The latter is important because PTSD treatment involves recollection and recounting of painful experiences, which has the potential to elicit negative outcomes.

The Brief Strategic Family Therapy (BSFT) trial and its 1-year follow-up has been completed. This family-based intervention was developed and tested for preventing and treating child and adolescent behavior problems, including substance abuse, in inner city, minority families. The data are being analyzed for future publication in scientific journals, and/or presentation at national and regional meetings. Previous research using BSFT found that it was more efficacious than group intervention in reducing conduct problems, associations with anti-social peers, and substance use, and it increased engagement in treatment. Moreover it improves family function, which is associated with changes in behavioral problems among youth. Final results of the trial will help determine whether BSFT can be readily adopted by community treatment programs.

NIDA also contributes to NIH's scientific research goal of identifying and characterizing human candidate genes that influence risk for substance use disorders and risk of psychiatric disorders. Several studies are working to identify vulnerability markers for addiction; for example, the gene polymorphism linked with substance abuse vulnerability in three independent case control samples (European American and African American). In addition, variation in genes controlling cell adhesion, enzymatic functions, transcription, and cell structure have been linked to methamphetamine dependence.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Resource Summary

	Budget Authority (in Millions)		
	FY 2008 Final	FY 2009 Enacted	FY 2010 Request
Drug Resources by Function			
Prevention	16.067	17.827	18.859
Treatment	71.422	75.761	79.950
Total Drug Resources by Function	**$87.489**	**$93.588**	**$98.809**
Drug Resources by Decision Unit			
Alcohol and Substance Abuse	84.082	90.181	95.402
Urban Indian Health Program	3.407	3.407	3.407
Total Drug Resources by Decision Unit	**$87.489**	**$93.588**	**$98.809**

Drug Resources Personnel Summary			
Total FTEs (direct only)	160	169	171
Drug Resources as a Percent of Budget			
Agency Budget (in billions)	$ 4.297	$ 4.536	$ 4.989
Drug Resources Percentage	2.04%	2.06%	1.98%

Program Summary

Mission

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives (AI/AN). IHS supports substance abuse treatment and prevention services as part of this mission. Tribes operate approximately 95 percent of alcohol and drug abuse programs under self-determination agreements. This allows for flexibility in designing programs.

Methodology

The Indian Health Service (IHS) includes the appropriation for Alcohol and Substance Abuse (excluding the amount designated as Adult Alcohol Treatment) and the 14 percent of the total Urban Indian Health appropriation that provides for alcohol and substance abuse prevention and treatment.

Budget

In FY 2010, IHS requests $98.8 million for its drug control activities. This is $5.2 million above the FY 2009 enacted level.

Alcohol and Substance Abuse

Total FY 2010 Request: $95.4 million
(Reflects $5.2 million increase from FY 2009)

The IHS formed the IHS National Tribal Advisory Committee on Behavioral Health (NTAC) in the spring of 2008. The NTAC is made up of an elected Tribal leader from each of the twelve IHS areas and they are charged with

advising the IHS on how to spend these funds which will serve the best interests of American Indians/Alaska Natives. The NTAC developed recommendations for a spending plan that will make FY 2009 appropriations available to the local level. These recommendations are based on the Methamphetamine and Suicide Prevention Initiative funding formula. Each of the 12 Area Directors work with their respective Tribes to develop a plan on how to best target the dollars in their Areas.

FY 2010 Total Changes (+$5.2 million): The FY 2010 Budget includes an increase of $1.6 million for Community Rehabilitation and Aftercare, an increase of $1.4 million for Regional Treatment Centers, an increase of $1 million for prevention and treatment of methamphetamine abuse, an increase of $0.6 million for contract health service, and other increases totaling $0.6 million.

Urban Indian Health Program-Alcohol and Substance Abuse Title V Grants

Total FY 2010 Request: $3.4 million
(Reflects no change from FY 2009)

The FY 2009 level includes funds for the Urban Indian Health Program, a portion of which is provided as grants to 34 urban Indian 501(c)3 non-profit organizations to carry out alcohol and substance abuse prevention and treatment activities in the communities they serve. All urban programs have active partnerships with their local Veteran's Administration programs to identify joint program initiatives.

Performance

Introduction

This section on the FY 2008 performance of the drug control portion of the IHS Alcohol and Substance Abuse program is based on agency GPRA documents and the OMB review.
The IHS Alcohol and Substance Abuse Program undertakes anti-drug abuse activities to raise community awareness and target high-risk groups in addition to educating staff on issues and skills related to substance abuse. In 2007, IHS' Tribally-Operated Health Programs (TOHPs), including its drug control activities, were assessed by OMB for FY 2005 and received an assessment rating of "Adequate."

IHS Alcohol and Substance Abuse Program		
Selected Measures of Performance	**FY 2008 Target**	**FY 2008 Achieved**
» Alcohol-use screening among appropriate female patients	41%	47%
» Accreditation rate for Youth Regional Treatment Centers	100%	91%

Discussion

The measures reported in the table include results from both Tribally-Operated Health Programs and Federally-Administered Health Programs. Currently, Tribally-Operated Health Programs have 17 measures, including alcohol- and health-related performance indicators.

The percent of appropriate female patients screened for alcohol-use (Fetal Alcohol Syndrome prevention) at Federally-operated facilities increased from 28% in FY 2006 to 47% in FY 2008, which is a 68% increase in screening over two years.

The accreditation measure – "Accreditation rate for Youth Regional Treatment Centers" – was not met in FY 2008. The FY 2009 performance target will remain 100% and the agency is confident that the target will be met.

IHS also conducts the Comprehensive Update in Substance Abuse and Dependence course. This course is provided twice a year to IHS/Tribal/Urban primary care providers to enhance professional skills in addiction prevention, intervention, and treatment. The program includes a section on prevention, recognition, and treatment of opioid dependence. Safe prescribing activities have become a high priority for IHS. Activities include the development of a lending library (video and slide materials) designed to improve provider in-service capability and community presentations. Approximately 50 primary care providers receive this training each year.